VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 241-2345
To Report Adult Abuse: (800) 564-1612
Fax (802) 241-2358

August 20, 2010

Jeanne McLaughlin, Director
Vna Of VT & NH
1 Hospital Court
Bellows Falls, VT 05101

Provider ID #: 477002

Dear Ms. McLaughlin:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **July 21, 2010**.

Follow-up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,

Suzanne E. Leavitt RN, MS

Suzanne Leavitt, RN, MS
Assistant Director

Enclosure

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VT477002	A. BUILDING _____ B. WING _____	C 07/21/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VNA OF VT & NH	1 HOSPITAL COURT BELLOWS FALLS, VT 05101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
H 001	Initial Comments An unannounced on site investigation was conducted by the Division of Licensing and Protection on 07/21/10. The following is a State Regulatory violation.	H 001	RECEIVED Division of AUG 0 4 10 Licensing and Protection	
H 520 SS=D	5.9 Requirements for Operation V. Requirements for Operation 5.9 A home health agency shall comply with all applicable state and federal policies, guidelines, laws and regulations. In the event that State and federal regulations differ, the more stringent shall apply. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the Agency failed to comply with State Regulations for 1 applicable client. (Client #1) Findings include: 1. Per the State of Vermont Choices for Care (CFC) 1115 Long-term care Medicaid Waiver Regulations, the requirement is that case managers make a 60 day 'face-to-face' visit as well as a monthly contact for CFC clients. Per record review, Client #1 did not receive case management on-site visits every 60 days nor monthly contact by the case manager. The clinical record had evidence of visits for 11/19/09, 01/11/10, 03/18/10 and 06/30/10. A 60 day visit was not made during the month of May 2010. In addition, there was no evidence of telephone contact during the months between home visits. Per interview on 07/21/10 at 2:30 PM, the Team Clinical Coordinator confirmed that the case manager did not conduct an on-site 60 day visit		**ID Tag** / **Plan of Correction** / **Comp Date** **520 SS** Agency will provide reinforcement to field staff on the regulatory requirements for supervision of CFC clients. — 8/6/10 Agency wil provide reinforcement to field staf on the regulatory requirements for monthly contact of CFC clients. — 8/6/10 Chart audits will be revised to include both review of monthly contact and supervision (face to face) contact for Waiver (CFC) clients (Attachment A). — 8/13/10 VP of Performance Improvement will monitor compliance with this standard through review of audits for Waiver (CFC) clients — 8/30/10 POC accepted 8/19/10 Linda J. Emmons RN	

Dawn D McLaughlin — TITLE President — (X6) DATE 8/2/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Division of Licensing and Protection

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H 520	Continued From page 1 nor monthly contact for Client #1.	H 520		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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G 000	INITIAL COMMENTS An unannounced on-site investigation was conducted by the Division of Licensing and Protection on 07/21/10.	G 000	RECEIVED Division of AUG 0 4 '10 Licensing and Protection	
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Based on record review and interview, the Agency failed to comply with accepted professional standards pertaining to nursing assessment for 1 applicable client (Client #2). Findings include: 1. Per interviews on 07/21/10 at 10:35 AM and 11:10 AM, the staff nurse and the nurse case manager respectively stated that during their most recent home visits, neither completed a visual skin integrity assessment for Client #2. During a home visit on 6/24/10 by the staff nurse and on 06/30/10 by the nurse case manager, the skin assessment was based upon the caregiver's statements and not by the nurses' actual observations. Per a hospital report dated 07/19/10, Client #2 was admitted with "incredible bed sores", "horrific multiple open areas" and "skin excoriation." Per interview on 7/21/10 at 2:30 PM, the Team Clinical Coordinator confirmed that the nurses did not follow acceptable professional standards for nursing assessment.			

ID Tag	Plan of Correction	Comp Date
G121	Agency will provide reinforcement to field staff on the acceptable professional standards for nursing.	8/6/10
	Education to field staff regarding complete and accurate documentation	8/6/10
	Develop custom report to identify bedbound clients to focus audits and education on completion of skin assessments for potential or real skin breakdown.	8/13/10
	VP of Performance Improvement will monitor compliance with this standard through review of audits for bedbound clients	8/30/10

POC accepted 8/19/10
Susan D. Emmons, RN

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joanne M. McLaughlin | TITLE: President | (X6) DATE: 8/2/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.